Dental Assistant Expired Registration Activation Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Dental Quality Assurance Commission
Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Washington State Department of Health

Application Instructions Checklist

You will be notified in writing if further documentation is required.

To ensure you have submitted the necessary fees and documentation, we encourage you to use the following checklist:

- ☐ **Pay Late Renewal Penalty Fee**.
- ☐ **Pay Current Renewal Fee**.
- ☐ **Pay Expired Registration Reissuance Fee**.
  All fees are non-refundable. You can check the online **fee page** for current fees.
- ☐ **1. Demographic Information:**
  Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

  Legal Name: List your full name, first, middle, and last.

  Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

  Birth date: Provide the month, day, and year of your birth.

  Birth place: Provide the city, state and country where you were born.

  Address: List the address we should use to send any information about your registration. Be sure to include the city, state, zip code, county, and country. This will be your permanent address with the Department of Health until we have been notified of a change. See **WAC 246-12-310**.

  Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

  Email: Enter your email address, if you have one.

  Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.
- ☐ **2. Other License, Certification, or Registration:** List in date order, most recent to later, all your credentials you have held since last being credentialed in Washington State. Include your last active credential in Washington State. Attach additional completed pages if you need more space.

- ☐ **3. Professional Experience:** In date order, most recent to later, list all your professional work experience since your Washington State credential expired. Attach additional completed pages if you need more space.
- ☐ **4. AIDS Education and Training Attestation:** Required by **WAC 246-12-240**.
- ☐ **5. Disciplinary Action Attestation:** Required by **WAC 246-12-040**.
- ☐ **6. Applicant's Attestation:** Required to be both signed and dated in order to process the application.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0251030000

Dental Assistant Expired Registration Activation Application

Please type or print clearly. Follow the instructions provided. It is the responsibility of the applicant to submit all required supporting documentation. Failure to do so may result in a delay in processing your application.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name	First	Middle	Last

Birth date (mm/dd/yyyy)	Place of birth		
	City	State	Country

Address

City	State	Zip Code	County

Country

Phone (enter 10 digit #)	Fax (enter 10 digit #)	Cell (enter 10 digit #)

Email address

Mailing address if different from above address of record

City	State	Zip Code	County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

Registration #_____ Issue Date_____

2. Other License, Certification, or Registration

State/Jurisdiction	Profession	Credential			Method of Credentialing	Currently In Force	
		Type	Number	Year Issued		No	Yes

3. Professional Experience

Type of experience of practice and location	start (mm/yyyy)	end (mm/yyyy)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS. This includes the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations.

I understand I must maintain records documenting said education for two years and be prepared to submit those records to the Department if requested. **I understand should I provide any false information, my license may be denied, or if issued, suspended or revoked.**

Applicant's Initials	Date

5. Disciplinary Action Attestation

I certify no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

Applicant's Initials	Date

6. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws
(Print applicant name clearly)

of the state of Washington the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

By: _____
(Signature of applicant)

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RCW/WAC and Online Web Site Links

RCW/WAC Links

Uniform Disciplinary Act..... UDA RCW 18.130

Administrative Procedure Act ..... APA RCW 34.05

Administrative procedures and requirements..... WAC 246-12

Dentistry laws .....RCW 18.32

Dentistry Rules ..... WAC 246-817

Dental Professionals Laws ..... RCW 18.260

Standards of Professional Conduct Rules..... WAC 246-16

On-Line

AIDS Training Resources ..... Reference Page

Dental Quality Assurance Commission ..... Web Page

Approved EFDA Education Programs .....School List

LISTSERV

To receive emails regarding important dental credentialing information, please join our interested parties list at ..... Web Page